
# Review of Ohio Department of Health Treatment Programs

**JMOC Staff Report**
**December 2015**

**Table of Contents**

# Project Overview

The treatment programs operated by the Ohio Department of Health (ODH) have been created over time to address certain gaps in health care for populations with specific conditions and/or of specific ages. Since their creation, these programs have evolved as treatments and clinical practices have improved.

With the decoupling of Medicaid and cash assistance in 1997, the Children's Health expansion (CHIP) in 2001, and the recent Medicaid expansion for low-income childless adults, more people receive health care through the Medicaid program. Since the passage of the Affordable Care Act (ACA) five years ago, many other coverage gaps that have persisted over time have been closed.

Since passage of the ACA, all of the ODH treatment programs have seen significant changes in the demand for services. This report looks at how the ACA and other changes have affected the treatment programs operated through the Ohio Department of Health and identifies opportunities to better integrate the services provided through these programs into the formal health care system with a goal of improving care and health and lowering costs in the Medicaid program.

While important to those enrolled, these programs do not provide comprehensive health coverage for those that they serve, and, therefore, leave consumers exposed to additional costs or with untreated conditions.

Change is a natural process for public programs. Our current system is fractured, which leads to inequities in care and among clients. In their current state, these programs reinforce current fractures and some drive consumers *from* rather than *to* comprehensive care that results in better care and health outcomes at a lower cost. Reforms in the ACA and the state's expansion of Medicaid require a full reassessment of current treatment programs.

People move up and down the income scale and change health plans frequently; therefore, the goal should be moving consumers to a comprehensive health care system that works for all, regardless of payer, rather than continuing our current piecemeal systems.

Ohio is not alone in this reassessment. Federal funding in these programs is substantial, and these programs are under review at the federal level as well. Compared to other states, Ohio has traditionally taken a narrow view of how these dollars may be used. Other states have been more aggressive and creative in their use of these funds. Ultimately, to move the needle on health care cost and quality, flexibility and long term commitment are needed to address the leading health issues in our state.

**Statutory Review**

Section 308.10 of Am. Sub. H.B. 64, the state's FY 2016-2017 budget bill, called for JMOC to review the treatment programs operated by the Ohio Department of Health including: the Ryan White Program; Breast and Cervical Cancer Screening; Bureau for Children with Medical Handicaps; Maternal and Children Safety Net and Reproductive Health programs; and Immunizations.

The budget called for the Joint Medicaid Oversight Committee (JMOC) to review the uses of and necessity for these programs before and after the enactment of the ACA and review funding sources, maintenance of effort requirements, and grant restrictions.

The budget also asked for an analysis and recommendations to maximize the integration of these programs into the formal health care system to achieve the goals set out in the JMOC statute – essentially reducing the rate of growth in health care spending while improving care and health outcomes.

**Project Approach**

The JMOC committee is fully aware of the larger problems in the overall health care system. Complexity and fragmentation in the overall health care system often leads to poorer health outcomes and higher costs. If consumers, particularly those with chronic health conditions, remain covered and engaged in care, overall costs can be reduced.

The ODH treatment programs have significant limitations. They have not provided comprehensive health coverage, but rather only covered care for certain diagnoses and/or for people in certain age ranges. To complete this work, JMOC staff assumed that comprehensive health care is the desired state.

Within all of these programs federal funding is substantial and flexible and provides some opportunities. To the extent that funding could be redirected to meet the larger population health goals of the state, these opportunities have been identified.

**Major ACA Changes Affecting ODH Treatment Programs**

The coverage expansions, though Medicaid and the Exchange, coupled with the individual mandate that requires everyone to have insurance coverage were implemented in 2014 and have had the largest impact on the ODH treatment programs.

The ACA also made a number of reforms to insurance including guaranteed issue, the elimination of lifetime limits, and coverage of pre-existing conditions. These have been particularly beneficial to populations who were very sick and who lost or were unable to get health care coverage when they needed it the most.

The ACA also requires coverage of preventive services without cost sharing. This provision has made cancer screenings and contraception more affordable for consumers.

Finally, closing the Medicare Part D donut hole helps to make prescription drugs more affordable for people on Medicare who need a number of drugs to maintain their health.

**Ohio's Uninsured Rate Has Fallen**

The number of Ohioans who are uninsured has fallen substantially. For adults between the ages of 19 and 64, the uninsured rate has fallen from 18.8 percent in 2010 to 8.7 percent in 2015. For children between the ages of 0 and 17, the uninsured rate has fallen from 4.6 percent to 2.0 percent.[1]

Ohio expanded Medicaid in January 2014. Since that date, total Medicaid enrollment has increased by more than 600,000 people.

The 2016 open enrollment process is ongoing; however, in 2015, 234,341 Ohioans purchased coverage through the marketplace. Of this, 84 percent were eligible for premium tax credits. The average monthly premium for plans selected by Ohio consumers was $389 and the average tax credit was $244. Most (51 percent) purchasing plans were between the ages of 45 and 64. Approximately 26,000 plans were purchased for children under the age of 18.[2]

**Challenges Remain but Opportunities Emerge**

The ACA has had a profound effect on ODH treatment programs, but this effect varies by program. Some programs are seeing decreases in caseloads or need, while others are seeing increases.

High and rising health care prices, particularly for prescription drugs, present one of the greatest challenges in the U.S. health care system. As a result, affordability continues be an issue for employers, consumers, and tax payers. To deal with the cost issue more employers and individuals are moving to high deductible plans. These can be a better value for those that are healthy; however, they can be expensive for those that are sick.

Federal funding underpins all of the programs reviewed. These funding streams have limits on uses; however, in some areas, the federal government is encouraging states to be more creative in the use of these funds to cover services that will lead to better health.

Nowhere is the opportunity greater than in the Ryan White Program– the availability of coverage through the expansion and the exchange offers the state the opportunity to contemplate what is needed to win the war on HIV/AIDS – which the CDC has long called a winnable war. Progress made to reduce disease transmission is a win-win for Ohioans at risk for this disease as well as the financial bottom line of the Medicaid program.

**ODH Analysis and Actions Related to the ACA**

In 2014, the ODH contracted with Mathematica to assess the impact of the ACA on their treatment programs. The Mathematica report focused on the impact of caseload changes due to the availability of subsidized health coverage through the Health Exchange and the Medicaid expansion. A copy of the Mathematica report can be found in Appendix A.

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[1] OSU Government Resource Center. 2015 Ohio Medicaid Assessment Survey Statewide Findings.

[2] Office of the Assistant Secretary for Planning and Evaluation. *Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report for the period: November 15, 2014 – February 15, 2015*. March 10, 2015. Available at: http://aspe.hhs.gov/sites/default/files/pdf/83656/ib_2015mar_enrollment.pdf.

In response to the report findings, ODH has built in planned lapses for FY 2016 for the four GRF line items. The table below shows planned lapses by line item. While these funds remain available to be spent, the agency anticipates spending about $3.3 million less. At the end of the fiscal year, these amounts would lapse to the General Revenue Fund.

| Line item | Name | FY 2016 Appropriation | Planned Lapse | % change |
|---|---|---|---|---|
| 440-416 | Mothers and Children Safety Net | $4,428,015 | $498,285 | 11% |
| 440-438 | Breast and Cervical Cancer Screening | $823,217 | $164,643 | 20% |
| 440-444 | AIDS Prevention and Treatment | $5,842,315 | $1,168,463 | 20% |
| 440-505 | Medically Handicapped Children | $7,512,451 | $1,502,490 | 20% |
| **Total** | | | **$3,333,881** | |

ODH reports that it is currently analyzing its programs and has not made a decision about FY 2017 appropriations.

# Ryan White Part B

The outbreak of the HIV/AIDS epidemic in the U.S. in 1981 precipitated one of the most serious public health crises in the history of the U.S. To date, over 650,000 people have died of AIDS in the U.S., while it is estimated that 1.2 million Americans are currently living with HIV.[3] Life expectancy and quality of life for persons living with HIV/AIDS (PLWHA) have improved dramatically since the outbreak of the epidemic, most notably through the development of highly active anti-retroviral therapy (HAART) in the mid-1990s. PLWHA who receive proper treatment can expect to have a life expectancy comparable to that of the U.S. population at-large.[4]

While extremely effective, HIV treatment is also extremely expensive – individual HAART drugs often cost over $10,000 annually and HIV patients in the Medicaid program cost approximately $20,000 annually - and requires strict daily adherence. HAART medications can also cause a host of side effects, complicating treatment adherence.[5] This is particularly problematic given that HIV/AIDS primarily affects people who are more likely to be uninsured.

Numerous public, non-profit, and private programs have been established since the beginning of the epidemic to fight HIV/AIDS. Chief among these is the federal program created under the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990. Congress has reauthorized Ryan White several times, most recently in 2009. This program is funded through federal grants, state match funds, drug rebates, and other funding sources and has multiple parts, the largest of which is Part B. Part B serves as coverage gap filler and connects PLWHA with lifesaving drugs and health coverage as a payer of last resort. The scope and focus of the Part B program has shifted as new treatment options have emerged and as the health care landscape in the U.S. has evolved.

The enactment of the ACA and Ohio's subsequent expansion of Medicaid coverage present an excellent opportunity to re-evaluate the role of Ohio's Ryan White Part B program. Ultimately, Part B can and should be a central tool in connecting PLWHA to care and treatment, ensuring that PLWHA remain in that care and treatment in order to maintain their health, and in reducing transmission of HIV to ultimately win the fight against HIV/AIDS.

**Clinical and Demographic Information**

The Human Immunodeficiency Virus (HIV) is a retrovirus that attacks the immune cells which help the body fight off infection, thereby weakening the body's immune system. Over time – a decade on average - this diminishes the body's ability to fight off infections. So-called opportunistic infections (OIs), which include certain rare cancers, bacterial, and fungal infections, comprise the end-stage of HIV

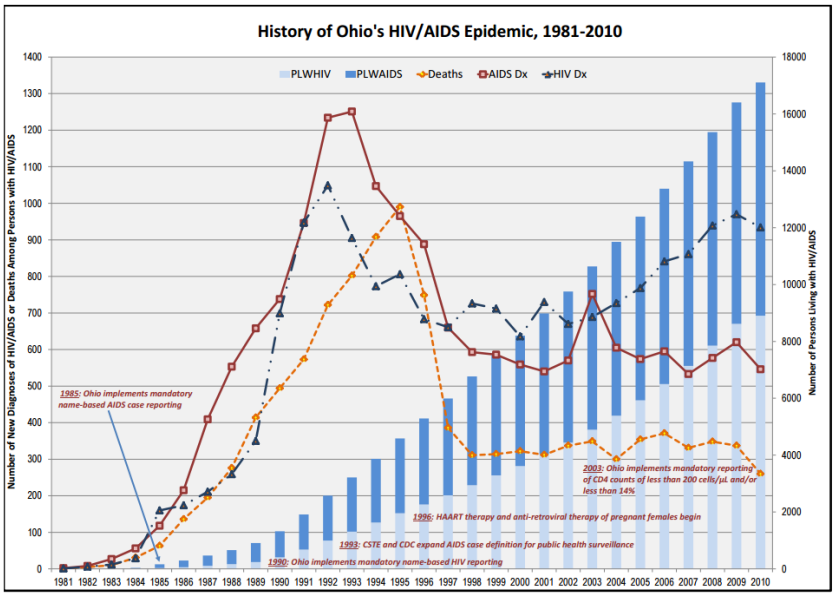
[3] U.S. Department of Health and Human Services. *HIV in the United States: At a Glance.* AIDS.gov. 2014. Available at: https://www.aids.gov/hiv-aids-basics/hiv-aids-101/statistics/.

[4] U.S. Department of Health and Human Services. *Aging with HIV/AIDS.* AIDS.gov. 2014. Available at: https://www.aids.gov/hiv-aids-basics/staying-healthy-with-hiv-aids/taking-care-of-yourself/aging-with-hiv-aids/index.html.

[5] National Institutes of Health. *HIV Treatment: the Basics.* Aidsinfo.nih.gov. 2014. Available at: https://aidsinfo.nih.gov/education-materials/fact-sheets/21/51/hiv-treatment--the-basics.

infection, known as Acquired Immunodeficiency Syndrome (AIDS). If left untreated, HIV/AIDS inevitably leads to death.[6]

The treatment and outlook for PLWHA has changed dramatically over time. From the beginning of the epidemic in the early 1980s through the mid-1990s, an HIV-positive diagnosis was tantamount to a death sentence; AIDS had become the leading cause of death for U.S. men age 25 to 44 by 1992 and the leading cause of death for all Americans ages 25 to 44 in 1994 and 1995.[7] The widespread lethality of AIDS was largely a result of a lack of any treatment to effectively combat the underlying HIV infection. This changed in the mid-1990s with the advent and widespread use of HAART to treat HIV infection. Since the mid-1990s, treatment for HIV/AIDS has evolved to the extent that HIV/AIDS has transitioned from a long-term death sentence to a manageable chronic infection.



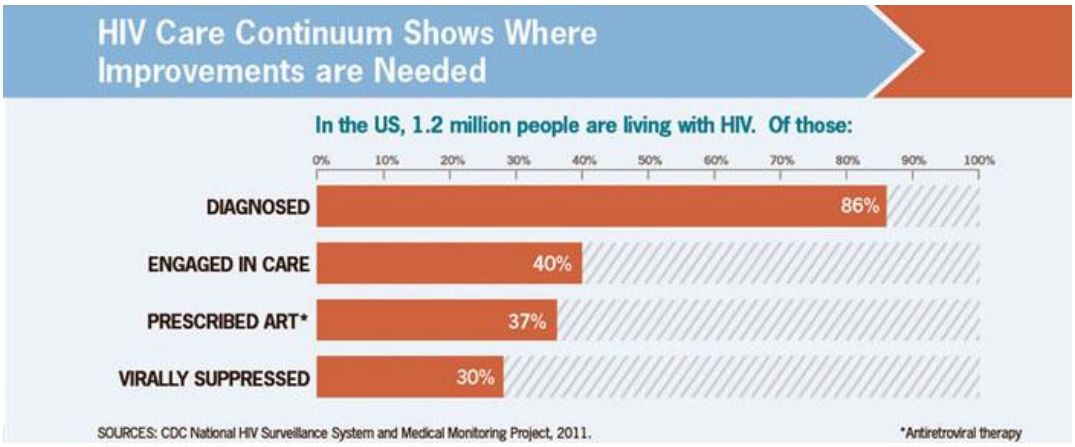

Source: Ohio Department of Health HIV/AIDS Surveillance Program
Note: Data represents Ohio cases diagnosed through December 31, 2010 and reported to the Ohio Department of Health through December 31, 2011.
Persons may be counted as both an HIV diagnosis in one year and an AIDS diagnosis in a subsequent year.
PLWAIDS = Persons Living With AIDS; PLWHIV= Persons Living With HIV; AIDS Dx = Persons Diagnosed with AIDS; HIV Dx = Persons Diagnosed with HIV;
Deaths = Deaths among reported HIV/AIDS cases; deaths are for all causes.
CSTE - Council for State and Territorial Epidemiologists; CDC - Centers for Disease Control and Prevention; HAART - Highly Active AntiRetroviral Therapy

The advancement in care and treatment of HIV/AIDS has been an enormously positive public health development. PLWHA who receive proper treatment can expect to have a normal life expectancy. HAART drug regimens stop HIV from reproducing in the body through various biological mechanisms and allow individuals to achieve what is known as "viral suppression" – the point at which HIV is undetectable in the individual's bloodstream. Individuals who achieve viral suppression reduce the risk of HIV transmission to a partner by 96 percent.[8] As such, it is critical that PLWHA be connected to care

[6] U.S. Department of Health and Human Services. *Stages of HIV Infection.* AIDS.gov. 2014. Available at: https://www.aids.gov/hiv-aids-basics/just-diagnosed-with-hiv-aids/hiv-in-your-body/stages-of-hiv/index.html.
[7] U.S. Department of Health and Human Services. *A Timeline of AIDS.* AIDS.gov. 2014. Available at: https://www.aids.gov/hiv-aids-basics/hiv-aids-101/aids-timeline/.
[8] Public Health Agency of Canada. *Undetectable Blood Viral Load and HIV Transmission Risk: Results of a Systematic Review.* 2013. http://www.catie.ca/en/catienews/2013-03-07/undetectable-blood-viral-load-and-hiv-transmission-risk-results-systematic-revi.

and receive proper treatment, not only for their own health, but also in order to prevent transmission of HIV.

But the nature of HIV is such that it never leaves the body, even when an individual has achieved viral suppression. Though the risk of transmission is reduced by 96 percent when an individual is virally suppressed, many PLWHA in Ohio – roughly 20 percent[9] – do not even know that they are infected with HIV. Of the roughly 80 percent of PLWHA who are aware of their infection, even fewer are connected to care, are receiving proper treatment, or have achieved viral suppression. This descending level of care is what is known as the HIV/AIDS treatment cascade or care continuum. Ohio does not track the care continuum for the state's overall PLWHA population, though the CDC provides an estimate of the number of individuals who are unaware of their HIV infection. Given the immense reduction in transmission risk associated with viral suppression, it is crucial that Ohio increases the level of care and treatment for PLWHA.




The connection to care and treatment for PLWHA is complicated by the demographics of this population. HIV/AIDS is a disease that carries a stigma and largely affects minority and marginalized groups, particularly men who have sex with men (MSM), African-Americans, low-income individuals, and intravenous drug users (IDUs). These groups are less likely to be insured and thus less likely to receive proper treatment.

Despite making up approximately 2 percent of the U.S. population, MSM accounted for approximately 57 percent of the 47,500 new HIV infections in the U.S. in 2010, and accounted for 72 percent of new HIV infections among all persons aged 13 to 24.[10] This rate is comparable in Ohio, as 537, or 57 percent, of the 950 reported new HIV infections in 2014 were attributed to MSM sexual contact.[11]

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[9] U.S. Centers for Disease Control and Prevention. *Prevalence of Diagnosed and Undiagnosed HIV Infection – United States, 2008-2012.* Morbidity and Mortality Weekly Report. 2015.
[10] U.S. Department of Health and Human Services. *HIV in the United States: At a Glance.* AIDS.gov. 2014. https://www.aids.gov/hiv-aids-basics/hiv-aids-101/statistics/.
[11] Ohio Department of Health. *State of Ohio HIV Infections Annual Surveillance Statistics.* 2015. http://www.odh.ohio.gov/~/media/ODH/ASSETS/Files/health%20statistics%20-%20disease%20-%20hiv-aids/WebTables12.pdf.

African-Americans also bear a disproportionate burden of the HIV/AIDS epidemic. Despite comprising only 12 percent of the U.S. population, African-Americans accounted for approximately 44 percent of all new HIV infections in 2010 nationwide. Further, nearly half of all new infections among African-American males occurred in the aged 13 to 24 group.[12] Ohio's rate of new infections was slightly higher than the national average in 2014, with 493, or 52 percent, of new HIV infections occurring among African-Americans. [13]

New HIV infections also primarily affect young people, with 31 percent and 26 percent of new infections, respectively, occurring in the aged 25 to 34 and aged 13 to 24 groups in the U.S. in 2010.[14] The trend in Ohio is similar to that of the U.S. overall; approximately 29 percent of new infections in 2014 occurred among the aged 13 to 24 group, while 32 percent occurred in the aged 25 to 34 group.[15] As with total new infections, the new infections in the younger age groups disproportionately affect African-American males.

**Program Overview**

The Ryan White Program consists of Parts A through F each of which provides different services. Part B is by far the largest in terms of funding, individuals served, and scope of services. Part B serves as a payer of last resort for PLWHA and serves as gap filler for services not covered by Medicaid, Medicare, or private insurance. Part B also provides limited care for uninsured PLWHA.

ODH administers Ohio's Ryan White Part B program. Part B is open to eligible Ohio residents who are HIV-positive and who have family income of less than or equal to 300% FPL. Ryan White Part B clients must re-enroll every six months. PLWHA enrolled in Ryan White Part B are eligible to receive certain services through the Ohio AIDS Drug Assistance Program (OHDAP), the HIV Health Insurance Premium Payment Program (HIPP), and the Ohio HIV Medicaid Spend-down Payment Program (OHMSDP).

The last major change to Ohio's Ryan White Part B program came in 2010 amidst an estimated $17.9 million OHDAP shortfall resulting from increased costs of enrollment, medications, and insurance premiums and decreased state funding due to the Great Recession. ODH reduced financial eligibility for Part B from 500% FPL to 300% FPL, established a waiting list, and removed some drugs from the OHDAP formulary.[16] The OHDAP program currently has no clients on a waiting list, though financial eligibility still

[12] U.S. Department of Health and Human Services. *HIV in the United States: At a Glance.* AIDS.gov. 2014. https://www.aids.gov/hiv-aids-basics/hiv-aids-101/statistics/.
[13] Ohio Department of Health. *State of Ohio HIV Infections Annual Surveillance Statistics.* 2015. http://www.odh.ohio.gov/~/media/ODH/ASSETS/Files/health%20statistics%20-%20disease%20-%20hiv-aids/WebTables12.pdf.
[14] U.S. Department of Health and Human Services. *HIV in the United States: At a Glance.* AIDS.gov. 2014. https://www.aids.gov/hiv-aids-basics/hiv-aids-101/statistics/.
[15] Ohio Department of Health. *State of Ohio HIV Infections Annual Surveillance Statistics.* 2015. http://www.odh.ohio.gov/~/media/ODH/ASSETS/Files/health%20statistics%20-%20disease%20-%20hiv-aids/WebTables12.pdf.
[16] Ohio Legislative Service Commission. *Ohio Department of Health Greenbook*. 2011. Available at: http://www.lsc.ohio.gov/fiscal/greenbooks129/doh.pdf.

stands at 300% FPL. The ODH Director has the authority to tighten financial eligibility or institute a waitlist if funding is insufficient.

In 2014, 6,598 (80 percent) of the 8,204 Part B clients enrolled in either OHDAP or case management services were male, 3,775 (46 percent) were African-American, and 3,350 (41 percent) were between the ages of 25 and 44. This population is largely low-income; in 2014, 4,672 (57 percent) of the 8,024 Part B clients enrolled in either OHDAP or case management had family income below 100% FPL, while another 997 (12 percent) had family income between 100% and 138% FPL.[17] Part B clients with income below 100% FPL are automatically assigned a case manager upon enrollment in the program, though case management is available to all Part B clients.

Ryan White Part B delineates services between core medical services and supportive services. Federal law requires Part B programs to use at least 75 percent of Part B grant funds on core medical services, and not more than 25 percent on supportive services. Part B programs may apply to HRSA to waive the requirement that core medical services comprise at least 75 percent of Part B grant expenditures if there is no waiting list for the AIDS Drug Assistance Program (ADAP) services and if core medical services are available to all individuals in the program. This gives Part B programs flexibility to address unmet needs of Part B clients that may underlie their HIV infection or other emerging health issues.[18]

**Core medical services include**: 1) outpatient and ambulatory health services; 2) AIDS Drug Assistance Program treatments; 3) AIDS pharmaceutical assistance; 4) oral health care; 5) early intervention services; 6) health insurance premium and cost sharing assistance for low-income individuals; 7) home health care; 8) medical nutrition therapy; 9) hospice services; 10) home and community-based health services; 11) mental health services; 12) substance abuse outpatient care; and 13) medical case management, including treatment adherence services.

**Supportive services include:** 1) non-medical case management; 2) child care services; 3) emergency financial assistance; 4) food bank and home delivered meals; 5) health education and risk reduction; 6) housing services; 7) legal services; 8) linguistics services; 9) medical transportation services; 10) outreach services; 11) psychosocial support services; 12) referral for health care and supportive services; 13) rehabilitation services; 14) respite care; 15) residential substance abuse services; and 16) treatment adherence counseling.

The ADAP earmark is the largest portion of Ohio's Part B grant –$15.9 million (68.6 percent) of the current $23.2 million federal Part B award for the Ohio AIDS Drug Assistance Program (OHDAP) program. ODH can use this funding to purchase HIV medications or to purchase comprehensive health care coverage on behalf of Part B clients, including the full payment of premiums, co-insurance, and deductibles.

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[17] Ohio Department of Health. *Data Fiscal Program.* 2015. Available at: http://www.odh.ohio.gov/odhprograms/hastpac/hivcare/Data%20Fiscal%20Program.aspx.

[18] U.S. Health Resources and Services Administration. *Policy Notice 13-07: Uniform Standard for Waiver of Cored Medical Services Requirement for Grantees under Parts A, B, and C.* Available at: http://hab.hrsa.gov/affordablecareact/13-07waiver.pdf.

State ADAPs may use up to 5 percent of the ADAP earmark to provide services to increase access to medications, adherence to medication regimens, and monitoring of progress to therapy, specifically to encourage, support, and enhance adherence to and compliance with treatment regimens, including related medical monitoring. Part B programs may apply to HRSA to increase this cap from 5 percent to 10 percent if the state demonstrates that such additional services are essential and in no way diminish access to HIV medications for ADAP clients.[19]

**Program Funding**

The HIV/AIDS Bureau under HRSA awards a grant to ODH to administer the Part B program. The Part B grant is awarded through formula and is comprised of six parts: 1) the Ryan White Part B Base and Emerging Communities (EC) component; 2) the AIDS Drug Assistance Program (ADAP) component – Ohio's is known as the OHDAP and is the largest portion of the Part B award; 3) the Base and EC Supplemental component; 4) the ADAP Supplemental component; 5) the ADAP Emergency component; and 6) the Minority AIDS Initiative (MAI) component. The federal government awarded funds to Ohio for only the Base/EC, ADAP, and MAI components for the current program year. The Part B program year runs from April 1 through March 31 of the following year.

In FY 2015, Ohio's Part B award totaled $23.2 million - $7.1 million through the Base and EC component, $15.9 through the ADAP component, and $0.2 through the MAI component. Ohio's Part B Program also carried $1.4 million of a possible $4.1 million in unspent federal funds from program year 2013-2014 over to program year 2014-2015, increasing the total available Part B award to $24.6 million. Of this, the Ohio Part B program expended $16.1 million, **leaving $8.5 million of federal Ryan White Part B funding unexpended.** Ohio sent these funds back to the federal government.

HRSA requires state matching funds through either cash or in-kind contributions. HRSA calculates a state's match rate based on the number of AIDS cases in that state relative to the rest of the U.S. The required state match for Ohio for the three most recent program years was:

- 4/1/2013 – 3/31/2014: $11,439,626
- 4/1/2014 – 3/31/2015: $11,502,251
- 4/1/2015 – 3/31/2016: $11,476,716

ODH is able to use three funding sources as state match. ODH expends GRF state match through line item 440444 – AIDS Prevention and Treatment. ODH also uses the 340B drug rebates received through OHDAP purchases as match. Ohio could also use DRC funding used to treat PLWHA in the state prison system (roughly $10 million in FY 2015) as match, though GRF and rebate expenditures currently satisfy Ohio's match requirement.

[19] U.S. Health Resources and Services Administration. *Policy Notice 07-03: The Use of Ryan White HIV/AIDS Program, Part B ADAP Funds for Access, Adherence, & Monitoring Services.* 2007. Available at: http://hab.hrsa.gov/manageyourgrant/pinspals/adheremonitor0703.html.

ODH expends Ryan White Part B funds through three separate line items:

- **GRF line item 440444, AIDS Prevention and Treatment**, which provides state funding as match for the purposes of the Ryan White Part B program;
- **DPF line item 440609, HIV Care and Miscellaneous Expenses**, through which ODH expends 340B pharmaceutical rebates received through OHDAP;
- **FED line item 440618, Federal Public Health Programs**, through which ODH expends federal Ryan White Part B/EC grant award funds.

**Ohio Department of Health Ryan White Part B Expenditures, FYs 2013-2016**

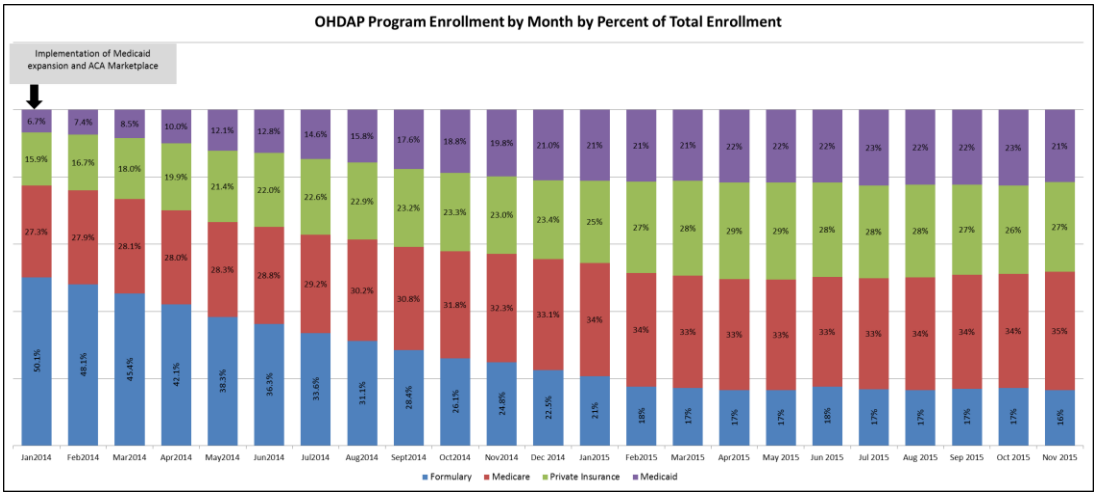
| Fund/Line Item | Line Name | Actual FY 2013 | Actual FY2014 | Actual FY 2015 | Estimate FY 2016 |
|---|---|---|---|---|---|
| GRF 440444 | AIDS Prevention and Treatment | $5,628,886 | $4,964,896 | $5,548,887 | $3,681,000 |
| DPF 440609 | HIV Care and Miscellaneous Expenses | $5,829,209 | $9,714,623 | $8,414,226 | $14,691,563 |
| FED 440618 | Federal Public Health Programs | $21,398,893 | $25,736,238 | $14,591,249 | $24,945,939 |
| **Total Program Expenditures** | | **$32,856,988** | **$40,415,756** | **$28,554,362** | **$43,318,502** |

In FY 2016, ODH has budgeted to leave unallocated 20 percent - or $1.2 million – of the GRF 440444 – AIDS Prevention and Treatment line item as part of its cost containment strategy. These funds can and should be expended given the number of new and undiagnosed HIV infections in Ohio.

**The Affordable Care Act and Subsequent Changes**

Part B has always served as critical gap filler for PLWHA but did not provide comprehensive coverage for the uninsured and underinsured, generally only covering HIV medications. The enactment of the ACA and implementation of Medicaid expansion have dramatically affected the health care coverage source of Ohio's Part B clients.

In January 2014, 6.7 percent of Ohio's OHDAP clients received health care coverage under Medicaid, 15.9 percent received coverage through private insurance, 27.3 percent received coverage through Medicare, and 50.1 percent received health care through the OHDAP formulary – which is to say they had no other form of health care coverage. Medicaid expansion and the ACA have drastically increased the number of OHDAP clients with comprehensive health insurance coverage. As of November 2015, 21 percent of Ohio's OHDAP clients received health care coverage under Medicaid, 27 percent received coverage through private insurance, 35 percent received coverage through Medicare, and only 16 percent received health care through the OHDAP formulary.




The coverage shift within OHDAP has been dramatic. The size of such a shift necessitates a re-focus of the Ryan White Part B program's services. Prior to the ACA and Medicaid expansion, roughly half of Ryan White Part B clients received health insurance coverage through the OHDAP formulary. This meant that OHDAP was their primary source of health care coverage and provided them with the medications necessary for treatment of their HIV/AIDS but not with comprehensive health care coverage. Given the complexity of the new health care landscape and the added complexity of dealing with HIV/AIDS, Ryan White Part B funding would be better put to use assisting Ryan White clients attain comprehensive health care coverage and providing necessary supports to ensure continuity of care.

**Program Challenges**

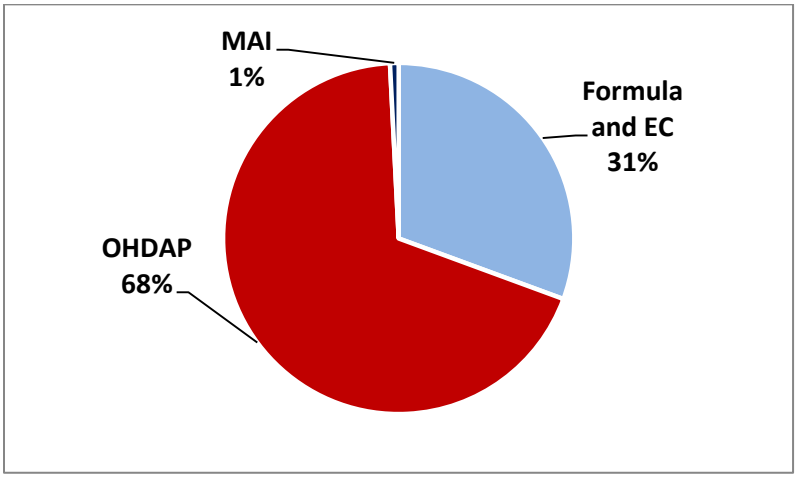
The Ryan White Part B program remains a critical instrument in the care and treatment of PLWHA and for the continued fight against the HIV/AIDS epidemic. The recent changes in the health care system necessitate a pivot in the outlook and focus of the program. There are a number of challenges facing the program from both a programmatic and population standpoint. These challenges are varied. Some stem from the treatment challenges and complex nature of the new health care landscape. Others stem from the demographics of the PLWHA population. Still others stem from gaps in the system for which the Ryan White Program provides a critical role.

***Funding Structure and 340B Pharmaceutical Rebates:*** Two of the biggest challenges facing the Part B program from a programmatic standpoint are its complex funding structure and federal requirements. Ohio's Part B program receives state funding, federal funding, and pharmaceutical rebates based on federal 340B pricing regulations. The rebate funding in particular complicates the financial structure of the Part B program. Ohio's Part B program must spend pharmaceutical rebates received before drawing down federal grant funding. The receipt of rebates by the program is unpredictable and necessitates a monthly review of funding, thus inserting an element of risk into ODH's financial and programmatic planning. Rebate funding could also complicate Part B planning through proposed federal regulations to limit pharmaceutical rebates for Ryan White Part B programs, increasing the program's financial uncertainty. The Part B program also operates on a unique timeframe – April 1 through March 31 of the following year – separate from both the Ohio and federal fiscal years. This complicates planning and

expenditures and requires ODH to balance three separate funding streams and three separate fiscal timelines.

***OHDAP Earmark:*** Another complicating factor is the size of the OHDAP earmark. The total federal Part B award for the current program year is $23.1 million, $15.9 million (68.6 percent) of which is earmarked for the OHDAP program. Federal regulations require OHDAP to spend money on purchasing medications or on the cost of premiums, co-pays, and deductibles for comprehensive health insurance. Any OHDAP money not expended within a Ryan White program year that is carried over to the next program year must also be spent on OHDAP functions. The preferred care model for Part B clients is to provide comprehensive coverage through the insurance exchange, Medicare, or Medicaid and using OHDAP funds to supplement prescription drug coverage not offered by the client's insurance. This is less costly to the program than purchasing clients' medications and providing other core medical services. Using OHDAP funds to provide comprehensive coverage for Part B clients allows the program to serve more clients and to provide a comprehensive level of coverage. While ODH has made great strides in enrolling clients into coverage, 17 percent of OHDAP clients still use OHDAP as their primary coverage source. ODH must continue to make a sustained effort to enroll all OHDAP clients into comprehensive coverage.

**Ryan White Part B Federal Grant, 2015**




**Medicaid Spend Down Program and Coverage Gaps:** Changes in Ohio's Medicaid program have also created challenges in the operation of Ohio's Part B program. The state will eliminate its Medicaid spend down program effective July 1, 2016. The Medicaid spend down program currently allows eligible individuals to spend down a portion of their income to reach Medicaid financial eligibility for persons with a disability, which is currently 64% FPL and assets of no greater than $1,500. The new guidelines raise financial eligibility to 75% FPL and assets of no greater than $2,000 to align with federal financial eligibility for Supplemental Security Income (SSI).

This will effectively eliminate the Ohio HIV Medicaid Spend-down Payment Program (OHMSDP) through Part B. Individuals no longer covered under spend down will either qualify for Medicaid under expansion, get coverage through the federal exchange, or through non-dual eligible Medicare. Medicaid would cover expenses for clients enrolled under expansion, while Ryan White would cover premiums,

co-pays, and deductibles for private insurance through the exchange. However, Ryan White would only be able to cover premiums and HIV-related co-pays and deductibles for Medicare enrollees, but would not be able to cover non-HIV related expenses.

There are also prescription coverage gaps in the private insurance marketplace for OHDAP clients. As of November 2015, 26 percent of Part B clients receive health care coverage through private insurance. A number of private health insurance plans do not offer a formulary expansive enough to cover the medications required by Part B clients.[20] The gaps in private insurance coverage could lead to adverse health outcomes by disrupting an individual's adherence to their regimen of medications; in some instances the individual might lose access to a medication altogether.

**Population Characteristics**

Many PLWHA contend with a number of barriers that can keep them from attaining an appropriate level of care and/or can hinder their continuity of treatment. This not only puts the individual at risk of adverse health outcomes, but also increases the potential for transmission of HIV to uninfected, high-risk individuals.

Drug use, needle sharing, and unprotected sex – all extreme risk factors for HIV transmission – are seen at much higher rates in the homeless and unstably housed populations,[21] which translates to a much higher risk for HIV infection. Individuals in these populations are much less likely to be aware of their infection, to have health care coverage, or to have a linkage to care relative to the rest of the population. This increases the risk of HIV transmission and the likelihood that an individual's HIV infection progresses to AIDS, resulting in severe and costly medical events and/or eventually death.

Even in instances in which an individual is aware of their HIV-positive status and has access to treatment, that individual is less likely to take advantage of treatment if they are unemployed, have a lower level of educational attainment, or live in poverty.[22] This is particularly salient, as young MSM and young African-American men – the demographics driving new HIV infections – are more likely to be unemployed, low-income, and have a low level of educational attainment.[23]

These demographic characteristics compound the problems faced by PLWHA. HIV/AIDS is a complex disease that requires a high level of both medical and non-medical attention. The Ryan White Part B program must shift toward assisting its clients with the barriers which might hinder effective treatment. This will represent a major step in using treatment as prevention and ending the HIV/AIDS epidemic in Ohio.

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[20] Avalere Health. *Patient Access to HIV Drugs in Exchange Plans is Limited Compared to Other Sources of Coverage.* 2015. Available at: http://avalere.com/expertise/managed-care/insights/patient-access-to-hiv-drugs-in-exchange-plans-is-limited-compared-to-other.

[21] Aidala, et al. *Housing Status and HIV Risk Behaviors: Implications for Prevention and Policy.* AIDS and Behavior. 2005. Vol. 9. No. 3.

[22] Cunningham, et al. *The Effect of the Socioeconomic Status on the Survival of People Receiving Care for HIV Infection in the United States.* Journal of Health Care for the Poor and Underserved. 2005. Vol. 16. 655-676.

[23] U.S. Department of Labor. *The African-American Labor Force in the Recovery.* 2012. Available at: http://www.dol.gov/_sec/media/reports/BlackLaborForce/BlackLaborForce.pdf.

**Opportunities Moving Forward**

These challenges afford ODH a number of opportunities to pivot more effectively into the post-ACA world. The Part B program should place a priority on obtaining comprehensive health care coverage – private insurance, Medicare, or Medicaid - for all eligible clients to ensure that they are able to address not only their HIV/AIDS but also with associated and underlying conditions. Comprehensive care also increases the likelihood that an individual remains connected with treatment, adheres to a medication regimen, and attains viral suppression, thereby reducing the risk of HIV transmission to others. At the end of the day, ODH can and should leverage and maximize the use of available Part B funds to provide a higher level of care to current Part B clients, increase outreach and education, and identify PLWHA who are unaware of their infection in order to stem the tide of the HIV/AIDS epidemic in Ohio.

***Increased Medical Case Management Services and Interface with HIV-positive Medicaid customers:***

ODH can better leverage its funding to ensure positive health outcomes for existing Part B clients and to reduce the risk of new HIV infections in Ohio. One of the core medical services offered under the Ryan White Part B program is medical case management, which is important in successfully managing an individual's HIV infection. The Part B program currently assigns a case manager and requires medical case management for all OHDAP enrollees with income under 100% FPL. Clients with income above 100% FPL have the option of receiving case management services.

The Part B program should also make every effort to increase the allowable amount of OHDAP funds spent on medical case management services. As mentioned above, state ADAPs may use up to 5 percent of the ADAP earmark to provide services to increase access to medications, adherence to medication regimens, and monitoring of progress to therapy, specifically to encourage, support, and enhance adherence to and compliance with treatment regimens, including related medical monitoring. States may apply to HRSA for a waiver to increase this amount to 10 percent. Most of the $8.5 million that Ohio's Part B program sent back to the federal government consisted of OHDAP earmark funds. It would make sense to leverage these funds to increase case management services, particularly for those also enrolled in Medicaid. Many clinicians and providers see the case management function as a major role for the Part B program moving forward.[24]

The Part B program should also extend its medical case management services to all HIV-positive Medicaid clients. The Medicaid program serves over 9,400 clients with an HIV/AIDS diagnosis, yet Medicaid covers fewer than 1,500 Ryan White Part B clients in any given month. This means that a large number of HIV-positive Medicaid customers are receiving no HIV-specific case management services. It is also unclear whether these Medicaid customers are in care, are taking their HIV medications, or have achieved viral suppression. HIV/AIDS is a complex disease and the health care system is complex in and of itself. Medical case management services would be highly beneficial to Medicaid customers to ensure appropriate and continuous care and reduce the risk of transmission to others.

[24] Sood, et al. *HIV Care Providers Emphasize the Importance of the Ryan White Program for Access To and Quality of Care.* Health Affairs. 2014. Vol. 33 No. 3. 394-400.

***Increased Supportive and Wrap Services for High-Risk Clients:*** The PLWHA population faces a unique set of challenges, including high levels of poverty, mental health and substance abuse issues, and other co-morbidities. The Ryan White Part B program should more aggressively provide supportive services such as housing assistance – including substance abuse recovery housing, transportation, and nutritional services in order to address the challenges faced by Part B clients. These services would increase the likelihood of treatment adherence and reduce the risk of negative health outcomes and the risk of transmission to others.

Supportive services are an allowable use of federal grant funds and 340B rebate funds under Part B. Federal law allows state programs to use up to 25 percent of Part B grant funds for supportive services. In the 2014-2015 program year, Ohio spent 99.1 percent of Ryan White Part B funds on core medical services and only 0.9 percent on supportive services. ODH should also use Part B GRF funds to provide medical wrap services not otherwise covered in order to ensure a full complement of care for all Part B clients and to ensure that no clients served by the Part B program fall through the cracks of the health care system.

***Outreach, Education, and Prevention:*** Part B base grant funds and state match funds could also be better put toward outreach, education, and prevention activities. ODH can and should play a major role in slowing and ultimately ending the transmission of HIV; ODH has named reduction in HIV transmission as a measurable outcome goal in the 2015-2016 State Health Improvement Plan addendum. Outreach to high-risk individuals is crucial in achieving this goal.

The CDC estimates that over 4,000 individuals in Ohio are infected with HIV but do not know it.[25] ODH should use Part B funding to identify these individuals through targeted HIV testing and connect them with comprehensive health care coverage through the OHDAP, if eligible. ODH should also embark on a more aggressive public awareness campaign dealing with HIV/AIDS. As noted above, HIV/AIDS still carries a stigma that acts as a barrier against proper education and conversation. ODH is in a position of authority and credibility to ensure that Ohioans know the risks of HIV/AIDS, know how it is spread, and know the consequences of infection. ODH should particularly encourage HIV testing for all in order to identify those individuals who are unaware of their infection in order to connect those individuals to care. Outreach efforts are allowable supportive services under Part B. Testing associated with outreach and prevention are also allowable supportive services with HRSA program officer approval. These efforts could also be done using GRF funds.

***Increased Data Aggregation for an Ohio-Specific Treatment Cascade:*** In order to slow and ultimately end the HIV/AIDS epidemic in Ohio, ODH and other stakeholders in the health care system need benchmark measures in order to gauge outcomes. It is critical that Ohio adopt rules to collect data on HIV/AIDS prevalence and treatment to develop an Ohio-specific treatment cascade. The Part B

[25] U.S. Centers for Disease Control and Prevention. *Prevalence of Diagnosed and Undiagnosed HIV Infection – United States, 2008-2012.* Morbidity and Mortality Weekly Report. 2015.

program should be a central player in this effort, as it connects to care a significant segment of Ohio's PLWHA population. Ohio must account for the entire PLWHA population in order to develop an accurate treatment cascade and outcome measures; as such, ODH must also engage Medicaid managed care plans, providers, and private insurance plans to aggregate infection and treatment data. An Ohio-specific treatment cascade will present a clear picture of Ohio's HIV/AIDS epidemic and allow ODH and ODM to better target treatment and prevention strategies.

**Impact on State Expenditures**

Increasing prevention, education and outreach, reducing transmission, and increasing the continuity of care for PLWHA and at-risk populations will have a significant impact on state expenditures, especially in the Medicaid program. Medical care for PLWHA is extremely expensive. HIV medications are very costly. PLWHA experience a wide range of co-morbidities at higher levels than the general population, and treatments for infections associated with AIDS are both costly and lengthy. In FY 2015, the Medicaid program spent over $190 million on services to more than 9,400 individuals with an HIV/AIDS diagnosis; this amounts to roughly $20,000 annually per person.

PLWHA will need treatment at some point or another. Roughly, 4,000 individuals in Ohio are unaware of their HIV infection, putting them at high risk of transmitting HIV to others. The health care system will be required to bear the costs of these individuals whether through private insurance coverage, Medicare, or Medicaid. This is where the concept of treatment as prevention is critical. Providing treatment to one individual to achieve viral suppression is costly, but it also reduces the risk of transmission to others to a minimal level. ODH through the Ryan White Part B program can and must leverage all of its available resources to the best possible usage in order to slow and ultimately end the HIV/AIDS epidemic. This serves the best interest of Part B clients and of the public at-large.

## The Breast and Cervical Cancer Screening Program

Ohio's Breast and Cervical Cancer Screening Program (BCCP) provides breast and cervical cancer screening and diagnosis for uninsured women with incomes up to 200% of the federal poverty level. Screenings for cervical cancer are available to women between the ages of 40 and 64 and mammograms for women between the ages of 50 and 64. Women between the ages of 40 and 49 are eligible for a mammogram if indicated by a clinical breast exam, family history, or other factors. Women diagnosed with cancer through this program are eligible for full health coverage through the Medicaid program as long as they are being treated for the cancer.

The program is currently operated by 11 regional enrollment agencies that find and enroll eligible women in the program.[26] Funding is allocated to each agency based on a formula that includes the number of BCCP-eligible women in the region, the incidence of abnormalities among BCCP-eligible women in the region, and previous grant performance. Program enrollment generally takes place over the phone or by mail. Once a woman is enrolled in BCCP, the enrollment agency schedules her for appropriate screenings with a participating provider in her area. The Department of Health reports that it has agreements with more than 700 providers across the state for this program. Once a woman is enrolled in BCCP, the enrollment agency is responsible for the provision of rescreening mammograms and Pap tests at recommended screening intervals.[27] Men are not eligible for screenings through this program.

The BCCP program receives federal funding from the Centers for Disease Control and Prevention through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). All 50 states currently receive funds from this program. Ohio has received federal funds for this program since 1994 and has provided GRF funding since 2007. Beginning in 2015, Ohio residents have been able to donate a portion of their income tax refunds to this program. In 2015, the tax check-off generated $87,170 for the BCCP program.[28]

Between July 2009 and June 2014, Ohio's BCCP program screened 30,973 women, performing 33,606 Pap tests and 50,220 mammograms. Of these, 632 cases of breast cancer and 472 cases of cervical cancers or premalignant cervical lesions were diagnosed.[29]

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[26] A list of regional entities and map their service regions can be found online at: http://www.healthy.ohio.gov/en/cancer/bccp/enrollags.aspx.

[27] NBCCEDP Program Guidance Manual Book 2, Policies and Procedures, Program Management, Partnerships, Revised 10/2012, page 8

[28] The income tax check off option must generate at least $150,000 over two years or the option will be cancelled. (ORC 5747.113)

[29] U.S. Centers for Disease Control and Prevention. *April 2015 submission for Ohio, National Breast and Cervical Cancer Early Detection Program (NBCCEDP).* Available at: http://www.cdc.gov/cancer/nbccedp/data/summaries/ohio.htm.

**Cancer Statistics**

Cancer is the second most common cause of death in Ohio. In 2012, 59,999 new cases of cancer and 25,246 cancer deaths were reported in Ohio. The chart below shows both the incidence and deaths for the leading types of cancers in Ohio.

| Primary Cancer Site/Type | New Diagnoses | | Deaths | |
|---|---|---|---|---|
| | Cases | Rate | Cases | Rate |
| Lung and Bronchus | 9,292 | 66.9 | 7,512 | 54.1 |
| Female Breast | 8,642 | 120.3 | 1,736 | 22.6 |
| Prostate | 6,877 | 103.7 | 1,066 | 19.2 |
| Uterus | 2,030 | 26.9 | 384 | 4.9 |
| Ovary | 822 | 11.4 | 597 | 7.8 |
| Cervix | 401 | 6.5 | 161 | 2.4 |

Source: Ohio Annual Cancer Report, 2015

While female breast cancer had the highest incidence rate (120.3 cases per 100,000 women), twice as many women died from lung cancer. According to the Department of Health, 69 percent of breast cancers were diagnosed early, with a five-year survival rate of 99 percent. Ohio's female breast cancer incidence rate is slightly less than the national incidence rate of 122.6 cases per 100,000 women.[30] Both the incidence and death rates for cervical cancer are lower compared to other cancers, including uterine and ovarian cancers.

According to the Ohio Cancer Profile, 75.8 percent of Ohio women meet the U.S. Preventive Services Task Force recommended screening guidelines for breast cancer and 81.5 percent for cervical cancer. Cancer is more likely to be diagnosed in the late stage for both breast and cervical cancers in Ohio compared to the nation. For breast cancer, 67.4 percent of Ohio cases were diagnosed in the early stage and 29.3 percent in the late stage compared with 70.5 percent and 27.9 percent, respectively, for the nation. For cervical cancer, 41.4 percent of Ohio cases were diagnosed in the early stage and 52 percent in the late stage compared with 45.2 percent and 49.1 percent, respectively, for the nation. [31]

**ACA Changes and Impact on Program**

Three provisions of the ACA have substantially impacted this program. First, the coverage expansions through the Medicaid program for low-income, childless adults and subsidized coverage through the exchange have significantly reduced the number of uninsured women in Ohio. In 2013, prior to these

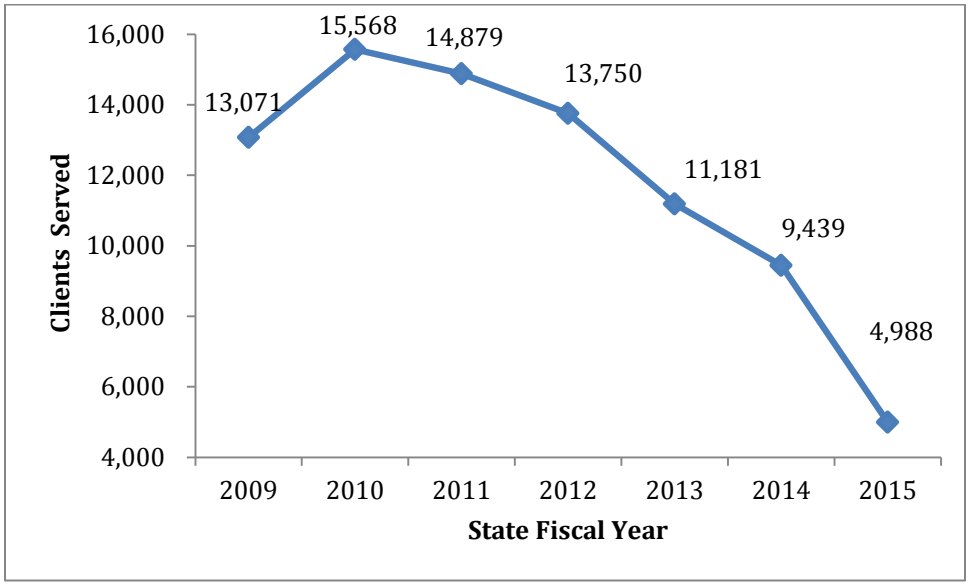
[30] U.S. Cancer Statistics Working Group. United States Cancer Statistics: 1999–2012 Incidence and Mortality Web-based Report. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute. 2015. Available at www.cdc.gov/uscs.

[31] Ohio Department of Health. 2015 Ohio Cancer Profile. Available at: http://www.healthy.ohio.gov/~/media/ODH/ASSETS/Files/opi/cancer%20incidence%20surveillance%20system%20ociss/Ohio%20Cancer%20Profile.pdf.

expansions, Ohio's uninsured rate was 11 percent. In 2014, Ohio's uninsured rate dropped to 8.4 percent.[32]

In addition, the ACA requires insurers to make recommended preventive services including mammograms, Pap tests, and the HPV vaccine available to patients without cost sharing. This requirement applies to all commercial plans – including individual, small group, large group, and self-insured plans. This provision has been in effect since September 23, 2010. The only exception is for plans that remain grandfathered. Note that while these screenings are provided without cost to the patient, patients may still face out-of-pocket costs for follow up care if the screening reveals a problem that requires additional diagnostic tests or treatment.

The chart below shows the number of women served by the program since 2009. Program enrollment peaked in 2010 and has been dropping since. It is interesting to note that program spending has fallen by 20 percent between FY 2013 and FY 2015, but that the number of women served has dropped by 55 percent. This has driven up the cost per woman screened from $460.59 in FY 2013 to $835.58 in FY 2015.




Many women who had been enrolled in this program became eligible for coverage, either through Medicaid expansion or the Exchange, and ODH reports that BCCP enrollment agencies were strongly encouraged to refer clients to these new options.

Even though 169 women were diagnosed through BCCP with either breast or cervical cancer in 2014 and 106 in 2015, the number of women enrolled in the Medicaid program through the BCCP option has fallen steadily since expansion, from a high of 926 people in November 2013 to 608 people today.[33]

[32] State Health Access Data Assistance Center. *Uninsurance Rates for Ohio in 2013 and 2014*. Available at: http://www.shadac.org/sites/default/files/Old_files/shadac/publications/aff_2701_OH_2013_2014.pdf.

During budget testimony before the Senate Medicaid Committee, Medicaid Director John McCarthy stated that during the first six months of operation, six percent of new enrollees in the expansion population had a primary diagnosis of cancer (of any type).[34] He also noted that more adults enrolled in Medicaid through expansion had a primary diagnosis of cancer than adults enrolled in the Aged Blind, or Disabled (ABD) or Covered Families with Children (CFC) groups.

In the FY 2016-2017 budget, the administration proposed flat state funding for the BCCP screening program and proposed ending Ohio's BCCP treatment program through the Medicaid Program. The legislature maintained funding for screening and reinstated the treatment program during the budget process. Other states have proposed eliminating their treatment programs as well, but to date, only Arkansas and New Hampshire have done so.[35]

**Program Funding Requirements**

State BCCP programs are required to match every $3 of federal funds with $1 of non-federal resources, either through cash or in-kind contributions. Both public and private contributions may be used to meet the state's match requirement.

Additionally, at least 60 percent of program funding must be spent on direct services. Direct services include screening and diagnostic tests, client intake and counseling, client transportation, and one-to-one recruitment. The remaining 40 percent may be spent on administrative functions including billing, public education, professional development, program evaluation, and disease surveillance.

**Program Funding**

The BCCP program is currently funded through the federal National Breast and Cervical Cancer Early Detection grant, Medicaid administrative claiming funds, General Revenue Fund (GRF), and the new income tax check off fund. Additionally, ODH claims in-kind spending based on the difference between billed and paid changes. The chart below shows funding levels for FY 2013-FY 2016. Highlights by funding source follow.

[33] Ohio Department of Medicaid caseload reports, May 2015 and October 2015.

[34] John McCarthy testimony. *Ohio Department of Medicaid: FY 16-17 Budget Priorities, before Senate Medicaid Committee*. May 5, 2015.

[35] American Cancer Society. *How Do You Measure Up? A Progress Report on State Legislative Activity to Reduce Cancer Incidence and Mortality*, *13th Edition*. 2015.

**Ohio Department of Health BCCP Funding, FYs 2013-2016**

| Fund | Actual FY 2013 | Actual FY 2014 | Actual FY 2015 | Estimate FY 2016 |
|---|---|---|---|---|
| GRF | $ 817,567 | $ 823,217 | $ 817,318 | $ 658,574 |
| Other State | $ 211,347 | $ 24,498 | $0 | $ 300,000 |
| Federal | $ 4,120,989 | $ 3,859,241 | $ 3,350,550 | $ 2,221,209 |
| **Total** | **$ 5,149,903** | **$ 4,706,956** | **$ 4,167,868** | **$ 3,179,783** |
| **Total # Served** | 11,181 | 9,439 | 4,988 | |
| **Total Cost per Woman Served** | $ 460.59 | $ 498.67 | $ 835.58 | |

***Federal:*** Ohio's federal grant for this program has remained fairly steady at $4.2 million per year; however, actual spending has been lower as Ohio has not been able to match the federal grant. The federal budget for FFY 2016 had not yet been passed at the time of this writing; however, the President's budget proposal reduces funding by 18 percent.[36]

***General Revenue Fund (GRF):*** The GRF appropriation for the BCCP for FY 2016 is $823,217; however, ODH has not allocated 20 percent of its GRF appropriation to align with expected savings identified in the Mathematica report. It is anticipated that these funds will lapse to the GRF at the end of the fiscal year.

GRF appropriation levels have been fairly steady over time at about $820,000 per year with the exception of fiscal years 2008 and 2009 when the program received an appropriation of $2.5 million per year.

***Other State Funds:*** The appropriation for FY 2016 from other state funds is $300,000. The sources for these funds are the income tax check off.[37] FY 2015 proceeds from the income tax check off totaled $87,170. The Department is able to match every $1 in income tax check off with $3 from the Health Transformation Innovation Fund, for up to $1 million.

One of the largest allocations through other state funds for the BCCP program was a one-time transfer of $3.5 million in FY 2011 from the now defunct Tobacco Use Prevention and Control Foundation. The bulk of these funds were spent in fiscal years 2011 and 2012 with some residual spending in 2013 and 2014 that appears on the chart above.

**Program Statistics**

Between grant year 2014 and 2015, the number of women served has dropped 46 percent. The number of women receiving mammograms has dropped by 47 percent, while the number receiving cervical cancer screens has dropped by 38 percent. More women served by the program received cervical cancer screenings than mammograms.[38] As a result of these screenings, 166 women in 2014 and 100

[36] FFIS Federal Grants Database, last updated March 13, 2015 to reflect the President's FFY 2016 budget proposal.
[37] The Human Services Innovation Fund is funded through CHIPRA performance bonuses.
[38] Note that the women are eligible for cervical cancer screening at age 40 and at age 50 for mammograms.

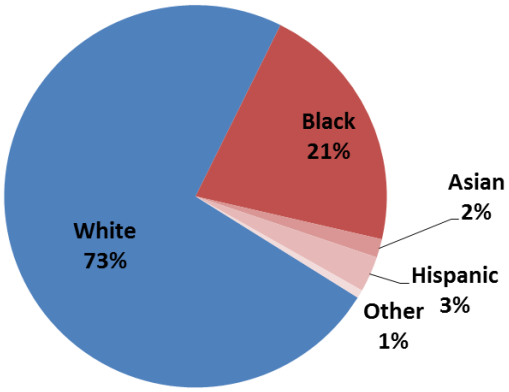
women in 2015 were found to have invasive breast cancer, and three women in 2014 and six women in 2015 were found to have invasive cervical cancer.

**Number of Women Served and Screenings Completed by Grant Year**

| | 2014 | 2015 |
|---|---|---|
| **Women Served (unduplicated count)** | 9,519 | 5,091 |
| **# Mammograms** | 6,223 | 3,299 |
| **# Cervical Cancer Screens** | 8,440 | 5,159 |

Ohio's overall population is roughly 80 percent white, 12.1 percent black, 3.4 percent Hispanic, and 1.9 percent Asian.[39] The chart below shows the distribution of women served in this program in 2014 by race and ethnicity. Most women served have been white, but the program is reaching a higher percentage of women (21 percent versus 12.1 percent) who are black. This is particularly relevant as the incidence of breast cancer among black women is on the rise and the death rate for black women is 42 percent higher than for white women.[40]

**Distribution of Women Served by Race/Ethnicity, 2014**




**Opportunities Moving Forward**

Clearly, the ACA has had a significant impact on this program, helping to eliminate the gap that this program was originally created to address. In the past, a number of Ohio women were un- or underinsured, and this program focused on ensuring that those women who were enrolled were regularly screened over time.

Currently, state funding has been allocated to this program through the FY 2016-2017 budget. For FY 2017, ODH reports that it plans to target funds within five regions in the state using a formula based on

[39] American Community Survey, 2014 population estimates.

[40] American Cancer Society. *Breast Cancer Rates Rising Among African-American Women.* October 29, 2015. Available at: http://www.cancer.org/cancer/news/news/report-breast-cancer-rates-rising-among-african-american-women.

overall population; areas of high need including high rates of incidence, morbidity, and late stage diagnosis; and insurance coverage rates.

Ohio has a history of spreading public health funds thinly across the state. While this helps ensure that no region is left behind, Ohio is a very large state and funding levels are often inadequate to address issues with the fidelity needed to move the needle on population health. This program is no exception.

In thinking of the future of this program and ways to meet the larger population health goals of the state, consider the following recommendations:

***Improve targeting of underserved at-risk women, particularly women who have never been screened.*** This program continues to miss a lot of women. There are currently approximately 135,000 women in Ohio between the ages of 45 and 64 who are uninsured.[41] In order to reduce the incidence and death rates due to breast and cervical cancer, the program must work harder to locate uninsured women, particularly minority women, who have never or rarely been screened and ultimately ensure that they are enrolled in comprehensive health coverage. ***This may require working with different partners to reach these populations.***

***Align rates with Medicaid***. The BCCP program pays Medicare Part B rates, which are adjusted annually, for all procedures and are higher than Medicaid rates. Federal regulations place a ceiling on BCCP rates at the Medicare maximum, but do not place a floor on reimbursement. This would free up resources to serve more women through this safety net program.

***Reduce the incidence of cervical cancer by improving HPV vaccination rates***. Since introduction of the HPV vaccination, HPV infection rates have significantly declined among those ages 14 to 19. The number of Ohio adolescents who have received all three doses of the vaccination remain low – 35 percent of all female adolescents.[42] According to the CDC, almost all cervical cancer is caused by HPV. Reaching the Healthy People 2020 vaccination rate goal of 80 percent would prevent 50,000 new cases of cervical cancer nationally.[43]

***Increase primary prevention activities***. According to the World Health Organization, 40 percent of all cancers could be prevented by eliminating four common risk factors: tobacco use, unhealthy diet, physical inactivity, and harmful alcohol use.[44]

[41] American Community Survey, 2014 population estimate.
[42] Ohio Department of Health. 2015-2016 State Health Improvement Plan Addendum. Pg. 13.
[43] Carroll, Aaron. *Good Talks Needed to Combat HPV Vaccine Myth*. New York Times. November 9, 2015.
[44] World Health Organization. *Raising the priority of non-communicable disease in development work at global and national levels*.

## Bureau for Children with Medical Handicaps

The Bureau for Children with Medical Handicaps (BCMH) program, initially established in Ohio law in 1921,[45] is the oldest of the ODH treatment programs and is one of the oldest children's treatment programs in the nation. Ohio's program predates Title V of the Social Security Act which created the federal Maternal and Child Health Program. Originally, the program addressed orthopedic issues caused by polio, nutritional deficiencies, or accidents. Over time as treatments have improved, the focus of this program has changed as well. The program now acts as a safety net primarily for children and youth with special health care needs (CYSHCN) who meet medical and financial eligibility requirements. CYSHCN are defined as children birth to age 21 who have or are at an increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.[46]

According to the most recent National Survey of Children with Special Health Care Needs, about 480,000 children in Ohio who were age 17 or under (18 percent of all children) had a special health condition.[47] Of these children, more than 148,000 had conditions that consistently affect their activities. The BCMH program serves a subset of this population.

The BCMH program does not provide comprehensive health care to its enrollees and instead fills gaps in coverage related to the child's special health condition. The program specifically excludes coverage of a number of health conditions, including behavioral health conditions and developmental delays. Unlike other health care programs, this program largely fills gaps in commercial coverage or Medicare for families with higher-than-poverty level incomes. BCMH, through its adult program, provides limited assistance for qualifying adults with cystic fibrosis or hemophilia.

Children are generally referred to the BCMH program by local health departments, children's hospitals, or other public service agencies.

**Programs Within BCMH**

BCMH offers specialized diagnosis, treatment, and management of complex medical conditions for qualifying children and adults. BCMH support helps families with private insurance maintain their employment and coverage. BCMH also helps its providers and parents navigate insurance utilization management processes, including prior authorization, and ensures appropriate payment of covered services.

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[45] Abt, Henry Edward. The Care, Cure, and Education of the Crippled Child. Elyria, Ohio: International Society for Crippled Children, 1924.

[46] McPherson M, Arango P, Fox H, Lauver C, McManus M, Newacheck P, Perrin J, Shonkoff J, Strickland B. "A new definition of children with special health care needs." *Pediatrics*, 102(1):137–140, 1998.

[47] 2009-2010 National Survey of Children with Special Health Care Needs, Ohio. Available at: http://mchb.hrsa.gov/cshcn0910/state/pages/oh.html

***Diagnostic Program:*** Children under age 21 can receive services from BCMH-approved providers for three months to diagnose or rule out a special health care need or to establish a plan of treatment. There are no financial eligibility requirements for this program.

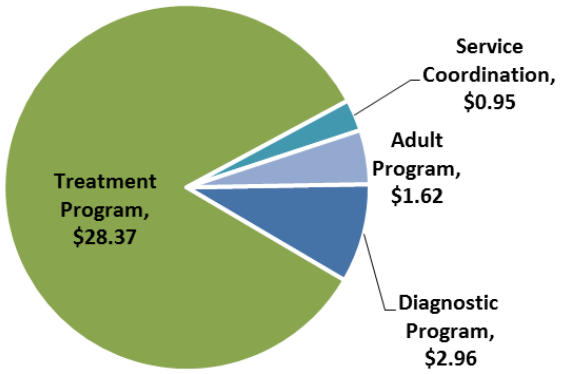
***Treatment Program:*** Children under age 21 with eligible health conditions can receive services from BCMH-approved providers for the treatment. Eligible conditions must be chronic, physically disabling, and amenable to treatment. Children and their families must meet medical and financial eligibility requirements to qualify for this program. Most children enrolled in this program have health care coverage through another payer as well. BCMH is the payer of last resort. The majority of BCMH funds are used for treatment services. In FY 2015, spending in the treatment program was $28.4 million.

***Service Coordination Program:*** The Service Coordination Program helps families locate and coordinate services for their child. This program is currently available for a limited number of diagnoses, and to be eligible, a child must be under the care of a multidisciplinary team at a BCMH-approved center. Financial eligibility is not required for this program. In FY 2015, just under $1 million was spent on this program.

***Adult Program:*** BCMH provides premium assistance for adults over the age of 21 with hemophilia or other bleeding disorders who meet medical and financial eligibility requirements. BCMH also provides limited treatment services for adults over the age of 21 with cystic fibrosis. The benefit package for adults with cystic fibrosis currently consists of some prescription drugs, medical supplies, and supplemental nutritional products, along with public health nursing services upon request. The number of adults with cystic fibrosis enrolled in this program has increased from 175 in FY 2008 to about 300 in FY 2015. There are currently about ten adults with hemophilia receiving assistance through this program.

The chart below shows spending by these four programs. Note that administrative costs are not included in this chart.

**Spending by BCMH Program, FY 2015** ($ in millions)



**Program Funding**

Primary funding sources for BCMH include county assessments, the Maternal Child Block Grant, General Revenue Funds, hospital audits and third party recovery, and Medicaid reimbursement for eligible administrative expenses.

***General Revenue Fund (GRF):*** To ensure the separation of spending for adults versus children, GRF funding for the program flows through two separate GRF line items. GRF funding for this program has ranged from a high of $12.5 million in FY 2001 to $7.7 million in FY 2015. Just over $6 million in FY 2016 from the Medically Handicapped Children line is used to match federal funds from the Maternal Child Block Grant. Note that the FY 2016 appropriation for line item 440505, Medically Handicapped Children was $7.5 million. ODH has not allotted 20 percent of this appropriation, or $1.5 million, due to identified savings reported by Mathematica.

Administrative costs related to serving BCMH children in other programs have been allocated to the following line items: Help Me Grow, Mothers and Children Safety Net Services, and Child and Family Health Services.

***Federal Funds:*** Federal support for the BCMH program comes from two primary sources: the Maternal Child Block Grant and Medicaid administrative claiming.

The Maternal Child Block Grant (MCBG) is the largest federal funding source for the BCMH program. States must use at least 30 percent of their federal allotment for services for children with special health care needs, and at least 30 percent for preventive and primary care services for children, and no more than 10 percent of each state's allotment may be used for administration. States are required to provide matching funds at a rate of $3 for every $4 spent. States also must maintain state spending at 1989 levels.[48] Funding levels for the MCBG have been fairly static. Ohio's annual grant is approximately $22 million.

Local health departments are able to use local funds to leverage federal Medicaid reimbursement, called Medicaid Administrative Claiming or MAC, for certain administrative expenses for Medicaid enrollees such as referral, coordination, and monitoring of Medicaid services. MAC claims are matched at 50 percent.

***Other State Funds:*** This category represents spending from non-GRF, non-federal sources, and includes two main sources of revenue: county assessments and recoveries and settlements.

County Assessments fund the majority of the BCMH program. Each county is billed for up to the value of 1/10$^{th}$ of an inside mill for treatment services not covered by federal funds or Medicaid that were

[48] Catalogue of Federal Domestic Assistance. Available at: https://www.cfda.gov/index?s=program&mode=form&tab=core&id=94fce2e39c433cb0fc42168a539d7e99.

provided to BCMH-enrolled children residing in the county. Cash in this fund exceeds current appropriation.

Revenues from third party recoveries and hospital cost settlements fund a portion of the program's administrative costs related to audits and recoveries. Remaining funds are used to pay for diagnostic and treatment services.

**BCMH Funding by Source**

| Fund/ALI | Line Item | FY 2013 | FY 2014 | FY 2015 | FY 2016 |
|---|---|---|---|---|---|
| GRF 440416 | Mothers and Children Safety Net Services | $0 | $0 | $ 565,248 | $0 |
| GRF 440452 | Child and Family Health Services Match | $ 3,451 | $0 | $0 | $0 |
| GRF 440459 | Help Me Grow | $ 1,180,592 | $ 1,849,663 | $ 767,356 | $ 572,956 |
| GRF 440505 | Medically Handicapped Children | $ 7,516,219 | $ 7,516,637 | $ 7,508,640 | $ 6,009,961 |
| GRF 440507 | Targeted Healthcare Svs Over 21 | $ 1,048,904 | $ 1,070,068 | $ 992,071 | $ 1,090,414 |
| | **GRF Total** | **$ 9,749,166** | **$ 10,436,368** | **$ 9,833,315** | **$ 7,673,331** |
| 1420 440646 | Agency Health Services (Medicaid Admin. Claiming) | $ 1,323,546 | $0 | $0 | $0 |
| 4700 440647 | Fee Supported Programs | $ 3,401 | $ 16,871 | $ 25,994 | $ 127,089 |
| 6660 440607 | Medically Handicapped Children - County Assessments | $ 19,247,224 | $ 23,231,363 | $ 23,200,982 | $ 19,739,617 |
| 4770 440627 | Medically Handicapped Children Audit | $ 2,649,433 | $ 2,644,085 | $ 2,536,086 | $ 3,677,428 |
| | **Non-GRF Total** | **$ 23,223,604** | **$ 25,892,318** | **$ 25,763,062** | **$ 23,544,134** |
| 3200 440601 | Maternal Child Health Block Grant | $ 4,154,402 | $ 4,078,556 | $ 5,772,552 | $ 6,112,923 |
| 3920 440618 | Federal Public Health Programs | $ 566,358 | $ 183,170 | $0 | $0 |
| 3GD0 654601 | Medicaid Program Support (Medicaid Admin. Claiming) | $0 | $ 1,983,817 | $ 1,678,356 | $ 1,607,879 |
| | **Federal Total** | **$ 4,720,759** | **$ 6,245,543** | **$ 7,450,908** | **$ 7,720,802** |
| | | | | | |
| | **Program Total** | **$ 37,693,529** | **$ 42,574,229** | **$ 43,047,285** | **$ 38,938,268** |

OBM's Office of Internal Audit did a review of the BCMH program in June 2015. At that time, the auditors estimated that the program was going to carryover about $9.4M in claims liability from FY 2015 to FY 2016 – 21percent of FY 2015 spending. This is not unusual due to the timing of claims submission and third party processing; however, it can become a sustainability issue for the program if the claims liability is growing as a share of overall spending.

Additionally, the elimination of Medicaid spend down will negatively impact the adult BCMH program. Without Medicaid spend down, the program will see increased expenditures for Medicare Part B co-pays and for prescription drugs. As such, it is likely that the Department will need to use its unallotted GRF funds and seek an appropriation increase to access county assessments that have been collected to maintain service levels in FY 2016.

**Recommendations from the 2006 Legislative Committee on the Future of Funding for BCMH**

In response to program cuts to BCMH made by the Taft Administration, Am. Sub. HB 66 of the 126th General Assembly restored cuts made to financial eligibility; allowed children enrolled in Medicaid to remain on the BCMH program; required all children eligible for Medicaid to enroll regardless of religious beliefs; and created the Legislative Committee on the Future Funding for BCMH. The committee was made up of 21 members including legislators, state agencies, the County Commissioners Association, BCMH recipients and parents, and other public health and health care associations. The committee divided its review among three subcommittees. The subcommittees looked into the issues of funding, payment strategies, and best practices in greater detail. A copy of the full report and recommendations can be found in Appendix B of this document.

After multiple public hearings, the committee issued a final report of findings and recommendations. While the report made a number of recommendations, the committee noted that it did not find the "one special fix" that would keep the program running over the long term and allow it to expand and grow.[49] The full committee made five short-term recommendations: increase fees on other health – related services; require manufacturer rebates for prescription medication and special nutritional formulas; bill counties for diagnostic services provided by BCMH; and increase state GRF funding. The committee also recommended that it be continued in some format.

For the longer term to increase *access to coverage*, the committee suggested expanding Medicaid, particularly to families with higher incomes and to children in need of home and community based care; creating a high risk insurance pool; increasing BCMH's use of premium assistance; and allowing BCMH families to buy into state employee health coverage.

Around the issue of *service coordination*, the committee suggested billing Medicaid for public health nursing services and reviewing service coordination in existing programs (Help Me Grow, Early Start, Maternal Child Health Services, and Public Health Nursing Programs) to eliminate the duplication of services.

With regard to the issue of *coverage of services*, the committee suggested restoring coverage for a number of BCMH services and conditions that had been eliminated including disposable undergarments for older children, inpatient hospitalization for adults with cystic fibrosis, and coverage for otitis media, hernia, sinusitis, and other conditions. The committee also suggested that the state create a single

[49] December 2006 Report from the Legislative Committee on the Future Funding of the Bureau for Children with Medical Handicaps. Page 4.

web-based application for all disability programs and that the legislature enact a mandate that health insurance plans cover special nutritional formulas.

Several reforms, particularly around access, were implemented. The state created a state-funded Medicaid buy in program for higher income children, added more home and community based Medicaid waivers, and operated a high risk insurance pool leading up to the 2014 implementation of the ACA. The Children's Buy In program and high risk insurance pool have since been discontinued.

**ACA Changes Affecting the Program**

The Mathematica report focuses on the impact of the ACA coverage expansions on ODH's programs; however, these expansions had a limited impact on the BCMH program. Most of Ohio's children already had health care coverage (about 4.8 percent or 126,000 children were uninsured in 2014).[50] However, the ACA made a number of insurance reforms that were beneficial for many children with special health care needs. Reforms impacting families with CYSHCN include:

- Prohibition on lifetime limits;
- Guaranteed issue and renewability;
- Coverage of pre-existing health conditions;
- Extension of dependent coverage to adult children up to age 26;
- Coverage options through the Exchange with premium subsidies and cost sharing limits for those meeting financial eligibility requirements; and
- Closing the gap on the Medicare Part D donut hole.

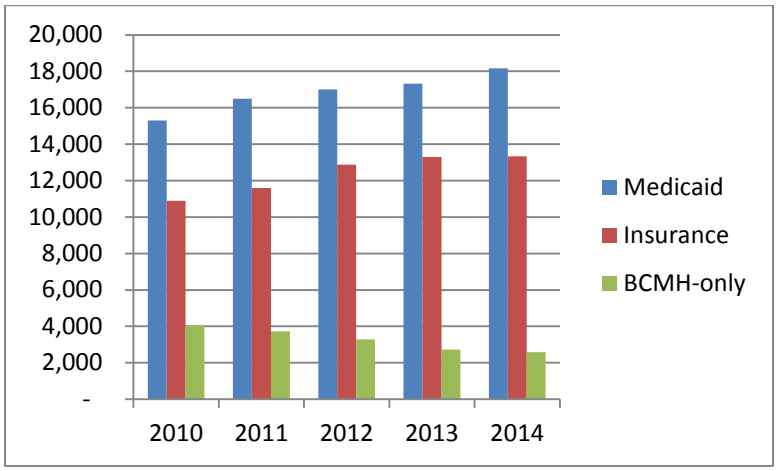
For families facing catastrophic illnesses, these insurance reforms have been monumental. Prior to their enactment, it was not unusual to have families lose coverage because their child exceeded his or her lifetime coverage limit or be denied coverage because of a sick child.

**Program Statistics**

The following series of charts look at BCMH caseload and spending by payer. Note that payer status may change throughout the year. For this series of charts, if an enrollee was enrolled in Medicaid any point during the year, that enrollee will be counted in the Medicaid category.

[50] American Community Survey, 2014 population estimate.

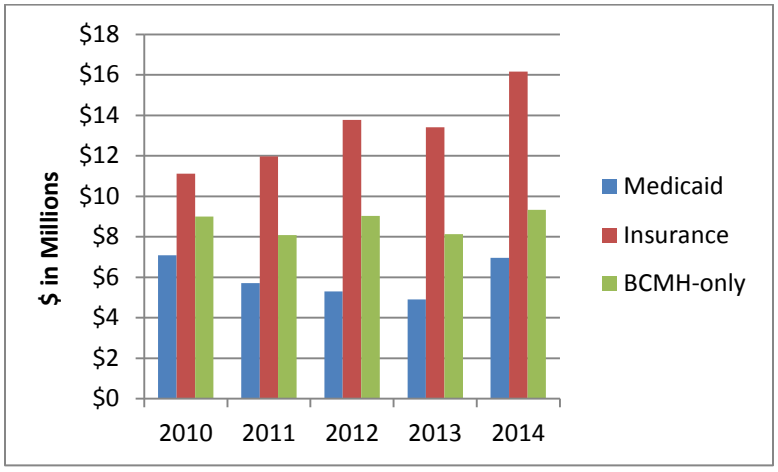
**BCMH Enrollees by Primary Payer**




Caseload includes all enrollees, including those with no BCMH claims payment. Some enrollees, particularly those with a cost share requirement, may not have had a BCMH claims payment in a year.

Most BCMH enrollees are enrolled in Medicaid. The number of Medicaid enrollees has been increasing, even though the number of children enrolled in Medicaid has been static. The number of program enrollees with insurance has increased, while the number of enrollees who relied solely on BCMH has declined.

**Annual Spending by Primary Payer**

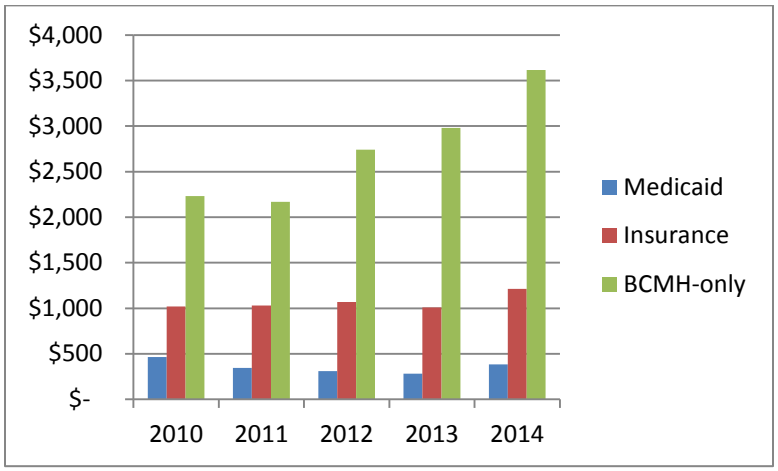



Annual spending data shows spending on a *paid* rather than *incurred* basis. Paid data does not account for delays in billing and payment that may vary by payer source.

The largest share of spending is for enrollees who have some form of insurance, which includes both commercial insurance and Medicare, and spending in this category is increasing. The second largest share is for BCMH-only enrollees. Medicaid represents the smallest share of total spending.

BCMH provides a financial benefit to families not captured on this chart. BCMH enrollees must seek care from BCMH-contracted providers. These providers agree to accept BCMH payment as payment in full with no backbilling for families.

**Annual Cost per Enrollee by Payer Source**




Costs on a per enrollee basis are highest for those who are covered solely by BCMH and these costs have increased substantially over time. Costs per insured enrollee are also rising. Medicaid costs on a per person basis are low.

**Program Use is on the Rise**

The use of this program is increasing; it is not clear why. BCMH lacks a formal front door, so it is not clear if the increase is due to the program reaching a greater share of eligible children, if the number of children with special health care needs is increasing, or if there is a larger issue with the rising cost of health care, particularly for children with special health care needs.

**Program Recommendations**

The changes in both the ACA and the larger health care system provide some challenges and some opportunities, both within this program and in the larger children's health care system. JMOC staff offer the following recommendations:

**Need more rigorous forecasting:** ODH staff has been diligent in its management of the BCMH program; however, the larger health care environment in which the program operates is changing rapidly. BCMH is a demand-driven program that people rely on. A high level of rigor is needed in this program to ensure it is able to fulfill its role. The caseload forecast should include information on enrollment and disenrollment by age group, by payer, and by month. The budget forecast should include monthly spending by category of service and by primary payer. The forecast should include an assessment of claims on an incurred as well as paid basis, and should include an analysis of costs by age and by diagnosis.

**Need a more refined knowledge of payers and consumers in this program:** With the changes in the ACA and the larger health reform movement, the dynamics of this program have changed.

Understanding how these larger system changes and their effect on BCMH caseload and spending is key to ensuring the program is able to continue to effectively meet is mission. A series of questions by category is listed below:

- **Uninsured:** Insurance coverage is not a prerequisite for BCMH, so little is known about the uninsured population other than that they are not eligible for Medicaid. Why are children still uninsured? Have they been uninsured for short or long periods of time? Do they have a hardship or other exemption from the individual mandate?

- **Medicare:** Medicare should be a separate payer category. How many BCMH Medicare enrollees are eligible and enrolled in Medicare Premium Assistance programs? What are the limitations of Medicare on the health care needs of children with special health needs and disabled adults? What options and challenges exist to filling Medicare gaps, such as Medigap and Medicare Advantage?

- **Commercial Insurance:** Who are the commercial payers in this program? Are individuals covered by small group or individual policies, the Exchange, or large or self-insured plan policies as the gaps and policy options are different for each? How is the increase in the self-insured market among smaller employers affecting this program? These plans are not subject to the same rules on benefit design and deductibles. Are plans carving out or charging higher rates for certain providers and for certain medications?

- **BCMH consumers:** What makes care unaffordable? Is it high premiums or deductibles, or is it out-of-pocket expenses for uncovered services or out of network providers?

- **Managed care:** A number of BCMH providers and parents have complaints about managed care, but there has been little engagement between families and plans. What are the issues with managed care and are they founded? Are there red tape issues that could be fixed?

**Align health-related programs to improve health systems for children with special health needs:** Interaction between BCMH and Medicaid has increased under the current administration. Covering 40 percent of Ohio's children – many of whom have special health care needs – Medicaid can and should be a driver for meaningful systems change. While some children may remain on the BCMH program long term, many will not, so it is critical that Ohio has a comprehensive system that works for all children. The BCMH program has in depth knowledge of the population it serves; however, it currently has limited ability to be strategic as it is less able to see the larger health system reform dynamics.

**Transition BCMH Medicaid children to managed care:** Under EPSDT requirements, Medicaid is required to pay for medically necessary services provided to children under the age of 21. Historically, BCMH has covered services that Medicaid would not. The Departments of Medicaid and Health have been working together on benefit packages and many of these gaps have been closed. Medicaid reports that all BCMH children will be carved into managed care by January 2017.

**Increase interaction with the Department of Insurance:** ODH spends a lot of time reviewing evidence of coverage and appealing decisions for services that should have been covered to ensure that it is the payer of last resort. These issues are never brought to the attention of the Department of Insurance, which has regulatory authority over health plans. ODI is, therefore, never made aware of emerging issues or larger systemic issues that it could work to address.

**Modernize financial eligibility standards:** The current financial eligibility standards for the BCMH program do not align with Medicaid, the state's largest health care program for children. BCMH should adopt the federal Modified Adjusted Gross Income, or MAGI, standards as they provide a common set of income eligibility rules that are used across all health care programs, making it easier for people to apply for health coverage through one application and enroll in the appropriate program. Using MAGI standards as a basis for financial eligibility would simplify the eligibility process and ensure BCMH is meeting its mission.

**Subject all divisions to financial eligibility requirements:** Diagnostic testing and service coordination are currently provided without regard to family income. In order to ensure the program can fulfill its mission in meeting the needs of the families it serves, all divisions should be subject to an assessment of financial need.

**Update payment policies:** BCMH currently pays inpatient and outpatient hospital claims using the cost-to-charge ratio from each hospital's Medicare cost report. Not only does this process cost BCMH money to perform audits to determine the cost to charge ratio, but it results in rates that are higher than both Medicare and Medicaid. Adopting Medicaid payment policies would require more sophisticated and expensive software. At a minimum, ODH should work with Medicaid and the children's hospitals to develop a fair rate that is less administratively cumbersome for all parties.

**Eliminate duplication in care coordination:** This is not a new recommendation, yet the problem still exists. Care coordination is a valuable service; however, many families with children with special health needs receive assistance from multiple public systems. In many cases, a family may have care coordination services from multiple programs. The duplication often creates conflicts between care managers or between providers and care managers, leaving families to manage multiple managers.

**Increased focus on transitions to adulthood:** Many children will "graduate" from BCMH, and planning is critical to avoid disruptions in care, poorer health outcomes, and higher costs. Other states have had a greater focus on improving transitions for children with special health needs as they move from the pediatric to the adult health care system and age off of their parents' health insurance. Transition activities could include helping youth take charge of their own care, learning how to manage their own health condition, understanding insurance options, and transitioning to adult providers.

## Maternal and Children Safety Net and Reproductive Health Programs

Maternal and child health is a priority area for both the legislature and the administration as the state works to lower our abysmal ranking for infant mortality. The problem of infant mortality is not solely confined to the Medicaid program, and the Department of Health must play a larger role in improving the systemic issues affecting Ohio's moms and kids.

**Program Funding**

| | Actual FY 2013 | Actual FY 2014 | Actual FY 2015 | Estimate FY 2016 |
|---|---|---|---|---|
| GRF | $3,571,856 | $2,971,646 | $3,054,490 | $2,870,934* |
| Federal | $10,568,884 | $13,061,969 | $12,076,499 | $10,408,056 |
| **Total** | **$14,140,740** | **$16,033,615** | **$15,130,989** | **$13,278,990** |

GRF funding comes from one line item, 440416, Mothers and Children Safety Net Services. These GRF funds are used to match the federal Maternal Child Block Grant and the Title X Reproductive Health Grant.

The Maternal Child Block Grant (MCBG) is the largest federal funding source for the BCMH program. States must use at least 30 percent of their federal allotment for services for children with special health care needs, and at least 30 percent for preventive and primary care services for children, and no more than 10 percent of each state's allotment may be used for administration. States are required to provide matching funds at a rate of $3 for every $4 spent. States also must maintain state spending at 1989 levels.[51] Funding levels for the MCBG have been fairly static. Ohio's annual grant is approximately $22 million.

In FY 2016, ODH has budgeted to leave unallocated 20 percent - or about $500,000 – of the GRF 440416 – Mothers and Children Safety Net Services line item as part of its cost containment strategy. Most funding in this area is for infrastructure and population health work. Given that Ohio ranks 45$^{th}$ nationally in overall infant mortality rates and 48$^{th}$ in mortality rates for African American infants, it is not clear why ODH is not planning to fully spend funds on systemic improvements in this area.

The Department currently spends very little on direct services, and this amount has been reduced over time. The Department reports spending a total of about $378,000 on direct services provided through the following local health departments for perinatal care and child and adolescent health care:

- **Perinatal:** Lake, Miami, Stark, and Warren
- **Child and Adolescent Health:** Ashtabula, Clermont, Geauga, Lake, Medina, Noble, Stark, Tuscarawas, and Warren

[51] Catalogue of Federal Domestic Assistance. Available at: https://www.cfda.gov/index?s=program&mode=form&tab=core&id=94fce2e39c433cb0fc42168a539d7e99.

Services are limited to individuals with incomes below 200% FPL – which is the Medicaid standard for pregnant women and children. The department listed a number of systemic issues that act as barriers to care for this population– that can and, frankly, should be resolved by Medicaid – including access to providers, access to care in a timely fashion, and transportation.

JMOC staff was unable to get program data from ODH for the Title X program and relied on Ohio data from the most recent federal Title X Family Planning Annual Report. This report noted – using 2014 data – that Ohio Title X clinics reported that 53 percent of clients had health insurance. Title X funded clinics in Ohio served about 65,000 women in 2014. This amounts to roughly three percent of the population of women of childbearing age.

Title X is a critical resource to women in underserved areas and in underserved populations. However, to move the needle on birth outcomes and reduce Medicaid caseloads, Ohio must have healthier moms. That means not only increasing access to family planning services, which becomes easier with broader coverage for more women, but also meeting a larger population health goal of ensuring that women are healthier before they get pregnant.

## Immunizations

A number of local health departments have had contracts with insurers to provide vaccine administration to their members for some time. ODH has been helping local health departments who did not have insurance experience and who wished to continue to offer vaccines to local residents to bill insurance plans for the service. The Department noted that state appropriations for immunizations have been reduced to reflect this change.

Since passage of the ACA, access to vaccinations has been enhanced: more people are covered and out of pocket costs for vaccines have been eliminated. In Ohio, pharmacists are now permitted to administer vaccinations for children under certain circumstances, so there are more places for people to go for vaccinations. However, Ohio's vaccination rates could be higher – especially for vaccines that require multiple doses like the HPV vaccine.

ODH maintains an immunization registry, known as ImpactSIIS. Reporting is voluntary, and access to the database is currently limited to providers, school nurses, local health departments, and WIC Clinics to help monitor compliance.

**Program Recommendations**

Not all providers participate in the registry, leaving children at risk for under or over vaccination. The Department should work to maximize provider use of this resource.

Additionally, consumers are mobile. They move into, out of, and around the state; they change doctors, and they change health plans. Ohio's strategies need to reflect this reality. Vaccination rates are HEDIS measures for all plans (commercial and Medicaid), so all parties are aligned on this common goal. Plans are another point for consumer education and outreach and provider alerts. Ohio needs more focus on this issue in order to improve vaccination rates and ensure that all children and adolescents receive their required vaccinations.

## Next Steps

The ACA has substantially changed the health care landscape – closing some gaps and opening new ones. A great opportunity exists to better align ODH's treatment programs with the overall population health goals set by the state. Ohio is currently missing opportunities that would not only improve health, but would save taxpayer dollars.

There are opportunities to operate programs with greater fidelity – we can no longer continue to spread a little bit of money everywhere and expect results. Funds must be targeted and programs must be held accountable for results. To eliminate health disparities, the right populations must be reached.

This review of the ODH treatment programs offers a look into these programs as they are and as they could be, but additional work is needed. We would recommend that the JMOC members lead a series of workgroups, each tasked with setting long term goals and developing future plans, for each of these programs in advance of the next state budget.